Bayou Health Provider Call – Summary
January 28, 2015

FOLLOW-UP ASSIGNMENTS	
1. Pregnancy Application Processing	See follow up in Q&A below
2. Delays in receiving TPL information due to DHH transition	
3. Protocol for Erroneous Assignments	
4. MCO Eyewear Policies	
5. Protocol for Billing an Emergency claim for a non-participating Provider	

Call Statistics:

- Number of Callers – 250 plus
- Number of Assignments – 5

Meeting Facilitator:
Mary TC Johnson, Deputy Medicaid Director

DHH Announcements
Communication:

- Call is every Wednesday from 12pm-1pm. Due to the participant volume everyone will be placed in listen only mode. If you want to speak hit *6 to unmute and then *6 to resume mute after speaking. Do not place us on hold. If you must hang up, keep in mind that there is a 250 person limit at this time.
- DHH received several emails and will respond directly to the senders as well as create an online FAQ sheet. Please continue to submit questions.
- Informational bulletin 12-27 was updated and is available with Health Plan and Molina contacts. Other recently updated informational bulletins, as well as, Health Plan Advisories are also on the makingmedicaidbetter.com.
- Sources of communication for providers:
  - *bayouhealth@la.gov*
  - Informational Bulletin 12-27 Providers Issue Escalation and Resolution (recently updated)
  - *www.MakingMedicaidBetter.com*
  - Health Plan Advisories
- Last Week's Call Summary has not been posted to date. It will be posted this week.

Follow-Up Assignment:

- **39 weeks Elective Deliveries**
  Several inquiries were received from physicians and hospitals on this issue. The information was revised. Last September DHH policy changed to no longer pay for elective delivers past 39 weeks. The new process for claims went live for fee for service. DHH has noted increase in delays in payment and higher initial denial rates due to claims not matching LEERS data and has been working with Molina, Vital Records and providers to remediate issues that will improve the flow of claims payment. Informational Bulletin 15-1 was posted today. Effective March 1, 2015,

the five (5) Health Plans will begin processing the edit for elective deliveries. The process will be similar to Blue Cross/Blue Shield, which is modifier based.

- **Carved in Services**
  EPSDT PCS: This is personal care services for members under 21 years of age. Effective Feb. 1 all members in Bayou Health will receive State Plan covered personal care services through the MCOs for members enrolled in Bayou Health (which includes some members in a waiver). Expanded waiver PCS/PCA services will continue to be provided through Legacy/FFS Medicaid. DHH will have a separate call with providers on Friday, January 30, 2015 from 9 a.m. 10 a.m. to discuss this change. The information about this call will be posted on www.MakingMedicaidBetter.com.

  Behavioral Health Protocol: Basic behavioral health services through primary care physicians will remain the same. Specialized behavioral health services are still with Magellan. Effective March 1, 2015 the responsible party (Bayou Health vs Magellan) will be provider based instead of diagnosis based. This information will go out this week and we plan to have a telephone conference on this issue which will include the MCOs, Magellan and the Office of Behavioral Health.

- **Shared Savings Plans**
  Effective February 1, 2015, Shared Savings Plans will no longer be in operation. Members in this type of plan had carved out services such as DME and pharmacy. These services will now be received through the MCO. Providers should have contracts in place with the member's new MCO to continue providing service. It is up to the MCO to know who is prior authorized for services and obtain the prior authorization files from Molina. There is a contractual element that the MCOs for the first 30 days honor the prior authorizations already approved by Molina or another MCO. During the 30 day timeframe we encourage providers to reach out to the MCO and for the MCO to reach out to the providers. If they cannot facilitate transition of care within 30 days, they must continue services until it has been completed.

Questions & Comments

Q: *If a member is erroneously assigned effective Feb. 1, what is the protocol to handle the issue?*
A: *DHH will have to review this and provide a response. The definition of erroneously assigned would be in DHH purview.*

Q: *Provider listings contain names of physicians' not enrolled with that particular MCO, what is the source of this information?*
A: *DHH sent out a broadcast to providers requesting that they go to bayouhealth.com Provider Search website to verify that all information is correct. If errors in information and assignments are noted providers should contact jode.burkett@la.gov or mark.perry@la.gov. DHH is holding Health Plans accountable for verifying their provider enrollments. Auto assignments may be reversed based on erroneous provider registry information. DHH is also spot checking and conducting sample calls but each*

provider is ultimately responsible for validating the information. Providers should also check each individual MCO website. The provider registry that we use is maintained by Molina and is used when DHH makes auto assignments. DHH will follow up on documented errors.

Q: In reference to the call with Magellan mentioned earlier, is there a website for providers to keep up with information regarding behavioral health?
A: MakingMedicaidBetter.com. There is a link on the first page to subscribe. DHH will also have a behavioral health specific call and information will be shared.

Q: If a provider is not credentialed with March Vision but is credentialed with United Healthcare will the credentials roll over?
A: This is specific to United. There is a link on the website with health plan contacts to reach out to United. DHH will also send contact information to United to reach out to provider.

Q: Is the new eyewear policy for members 21 and over online?
A: This is a value added benefit which varies by plan. A summary of benefits is available at https://bayouhealth.com/LASelfService/en_US/pdfs/LA-BenefitsCompChartOE.pdf Providers can contact each MCO for details regarding their policy.

Q: If we want to opt out of adhering to the new eyewear policy for members 21 and over do we have that option?
A: It depends on the contract that you signed with each MCO. This is very specific to your contract with the MCO.

Q: We had 496 denials on claims for deliveries over 39 weeks, can DHH provide any direction? Should we be receiving these denials? Will the claims be recycled?
A: DHH will publish guidance on how providers should follow up on these denials. Providers will either need to contact United Healthcare, Community Health Solutions Molina directly. The informational bulletin on this should be published today. The issue identified is that information is not in LEERS or does not match data in LEERS which causes the claim will deny. For now, this is only affecting Shared Plans. Other Health Plans will go active with denials on Feb. 1. The process with be similar to Blue Cross/Blue Shield. The purpose for this edit is to eliminate non-elective deliveries less than 39 weeks and to make sure that we have good birth outcome data. LEERS, the birth outcome system, is a big component of obtaining this data. DHH is trying not to create provider barriers. There is a retroactive look back that the Health Plans will do to clear data. If providers use modifiers correctly and are not doing a non-medically necessary delivery, the claim will not deny. This will be covered in Informational Bulletin 15-1 and specifics can be found on www.MakingMedicaidBetter.com.

Q: Providers have attempted to contract with United Healthcare and were told that they are not accepting any new providers, is there any recourse for these providers?
A: Please send an email with the specifics to bayouhealth@la.gov and staff will follow up with you. Even if you are not contracted with United they still must honor prior authorized services for up to 30 days until transition of care is completed. The MCOs must meet network adequacy but they are not required to contract with every provider in the state.

Q: For hospice billing on dual-eligible members, will billing remain the same?
*A: Yes. Dual-eligible members are **not** in Bayou Health and nothing will change regarding billing. If in Bayou Health, all of their services except for a small hand full are included in the Bayou Health plan. For these members the hospice should be billed to the Bayou Health plan. The Health Plan is responsible for determining what is covered in their hospice services. This may be different with each MCO. For non-emergency ambulance services, you should be contracted with Logisticare and send the claim to the managed care entity.*

Q: If a member presents to the OB clinic in their second or third trimester with CHS, will they require prior authorization for those services?
***A**: The same rules will apply as outlined in the informational bulletin 12-4. If the member is in a certain trimester they can stay with their current provider. Open enrollment will open again Feb 1, 2015 through April 29, 2015 and all members will have the opportunity to change at will.*

Q: Will LHC honor prior authorizations previous approved by CHS?
A: Yes

Q: If a provider is not participating with a Health Plan and have a patient present in the office with an emergency, how will they be paid?
A: Emergency services, as defined in the RFP/Contract, have to be paid by any MCO at 100% of the Medicaid rate without prior authorization and regardless of network participation. There are stipulations regarding the place of care. Submit question in writing and DHH will provide the exact language.

Q: How will physicians be paid for newborn care in the hospital if not participating with a payer?
A: This is addressed in informational bulletin 12-5. A physician must be paid whether in or out of network.

Q: Are all circumcisions covered by the MCOs?
A: Medicaid does not cover circumcisions but all five (5) Health Plans have agreed to pay for them within so many days of birth. DHH will compose an informational bulletin on circumcisions. This is a voluntary benefit being offered by the MCOs for newborns.

Q: Will prior authorizations that are still pending on Feb. 1 be honored?
A: The contract stipulation is only for approved prior authorizations. Providers will need to contact each MCO regarding how they will handle pending prior authorizations.

Q: Do the MCOs have hospice specific resources?
A: DHH does not have specific hospice guidance posted yet. DHH is working with the hospice association and hospice providers. DHH will compose an informational bulletin and include any information we can

link to the individual Health Plans. I do know that UHC doesn't require prior authorization for the initial move but the other Health Plans may. All will be combined in an informational bulletin.

Q: When a patient who receives inpatient services becomes eligible after the date of service and the provider needs to submit a pre-cert for the inpatient stay, how will this be handled?
A: The Health Plans are taking on cases without the ability to manage the care. DHH is writing out the boundaries and providing direction on this. There will be a fairly standardized process. DHH will consider whether it is medically necessary and provide specific language around this to share with the Health Plans and providers. The Health Plans are responsible for up to 12 months prior to the member being assigned to their plan. This is new to the Health Plans so DHH wants to walk through it with providers to have a good process in place. We do want to remediate as much of it as possible up front.

Q: If a provider is credentialed with the commercial side of an MCO's insurance will they need to re-credential?
A: It is up to the MCO. Each may be different. Providers will have to contract with the MCO because it is a different program. This question is Health Plan specific. DHH may research the answers and post on the Q and A.

Q: Will members be enrolled directly into Bayou Health without going into fee for service?
A: This is correct. If a member is eligible, they will go directly to Bayou Health.

Q: Who should we submit retro-reviews to when members go directly into a health plan upon Medicaid approval?
A: Submit to the Bayou Health MCO or Molina as listed on MEVS/REVS for the date of service. For claims up to 12 months of eligibility prior to enrollment the Health Plans will be responsible. If beyond 12 months it may go back to Molina.

Q: *What will happen to members who are not with UHC or CHS and just show as Legacy Medicaid?*
A: *If they are not in a Bayou Health Plan they will continue to get their services through Molina.*

Q: *What should a provider do about a parent who was not reached during open enrollment?*
A*: Provide contact information and specifics to the attention of Lesli Boudreaux at bayouhealth@la.gov and we will reach out to the parent.*

Q: *For billing purposes who do we send claims to for babies born prior to Feb. 1 and go with another plan effective Feb. 1?*
A: *DHH already has policy on this. The plan on date of admission should follow through discharge. If we get into a long term situation such as a NICU inpatient situation, DHH may have to look back at that.*

Q: *If a member comes in inpatient with one Plan and then changes Health Plans the next month, will the first Plan pay the inpatient hospice stay?*
A*: Yes that it is policy. Whoever the Plan was at admit will pay for the stay. If the patient admitted under CCN-S Plan coverage the provider may need to be split bill because Health Plan will no longer*

receive a capitated payment on those. Until the provider is notified of a new plan, the provider will bill the admit plan.

Q: *What is the LaHIPP policy change effective this weekend?*
A: *In general we are going to LaHIPP being considered like any other TPL. Medicaid will be secondary.*

Q: *What about existing LaHIPP patients?*
A: *The policy has not changed prior to Feb. 1.*